

AMENDED IN SENATE MAY 11, 2005
AMENDED IN SENATE APRIL 28, 2005
AMENDED IN SENATE MARCH 30, 2005

SENATE BILL

No. 364

Introduced by Senator Perata

February 17, 2005

An act to amend Section 1371.35 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 364, as amended, Perata. Health care service plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Under existing law, a health care service plan is required to reimburse within a designated timeframe, a complete claim submitted by a provider, and this responsibility is not waived by the plan requiring its contracting entities to pay claims for covered services.

This bill would authorize a physician who has a contract with a plan but not with a contracting entity of the plan, to submit a claim to the plan, and would require the plan to pay the claim pursuant to the terms of the contract between the plan and the physician. The bill would prohibit a physician ~~submitting such a claim~~ *that has a contract with a plan* from billing the patient for ~~costs~~ *services covered by the plan* that are not the responsibility of the patient.

Because the bill would specify an additional requirement for health care service plans, the violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. The purpose of this act is to protect patients
2 who are enrollees of health plans regulated under the
3 Knox-Keene Health Care Service Plan Act of 1974 from being
4 billed for emergency medical services provided by
5 noncontracting emergency and on-call physicians. A secondary
6 purpose of this act is to reduce the number of billing disputes
7 between emergency and on-call physicians and health plans and
8 their subcontractors. These purposes are accomplished by
9 increasing the number of claims that can be paid through
10 contracted relationships between health plans and emergency and
11 on-call physicians.

12 SEC. 2. Section 1371.35 of the Health and Safety Code is
13 amended to read:

14 1371.35. (a) A health care service plan, including a
15 specialized health care service plan, shall reimburse each
16 complete claim, or portion thereof, whether in state or out of
17 state, as soon as practical, but no later than 30 working days after
18 receipt of the complete claim by the health care service plan, or if
19 the health care service plan is a health maintenance organization,
20 45 working days after receipt of the complete claim by the health
21 care service plan. However, a plan may contest or deny a claim,
22 or portion thereof, by notifying the claimant, in writing, that the
23 claim is contested or denied, within 30 working days after receipt
24 of the claim by the health care service plan, or if the health care
25 service plan is a health maintenance organization, 45 working
26 days after receipt of the claim by the health care service plan.
27 The notice that a claim, or portion thereof, is contested shall
28 identify the portion of the claim that is contested, by revenue
29 code, and the specific information needed from the provider to

1 reconsider the claim. The notice that a claim, or portion thereof,
2 is denied shall identify the portion of the claim that is denied, by
3 revenue code, and the specific reasons for the denial. A plan may
4 delay payment of an uncontested portion of a complete claim for
5 reconsideration of a contested portion of that claim so long as the
6 plan pays those charges specified in subdivision (b).

7 (b) If a complete claim, or portion thereof, that is neither
8 contested nor denied, is not reimbursed by delivery to the
9 claimant's address of record within the respective 30 or 45
10 working days after receipt, the plan shall pay the greater of
11 fifteen dollars (\$15) per year or interest at the rate of 15 percent
12 per annum beginning with the first calendar day after the 30- or
13 45-working-day period. A health care service plan shall
14 automatically include the fifteen dollars (\$15) per year or interest
15 due in the payment made to the claimant, without requiring a
16 request therefor.

17 (c) For the purposes of this section, a claim, or portion thereof,
18 is reasonably contested if the plan has not received the completed
19 claim. A paper claim from an institutional provider shall be
20 deemed complete upon submission of a legible emergency
21 department report and a completed UB 92 or other format
22 adopted by the National Uniform Billing Committee, and
23 reasonable relevant information requested by the plan within 30
24 working days of receipt of the claim. An electronic claim from an
25 institutional provider shall be deemed complete upon submission
26 of an electronic equivalent to the UB 92 or other format adopted
27 by the National Uniform Billing Committee, and reasonable
28 relevant information requested by the plan within 30 working
29 days of receipt of the claim. However, if the plan requests a copy
30 of the emergency department report within the 30 working days
31 after receipt of the electronic claim from the institutional
32 provider, the plan may also request additional reasonable relevant
33 information within 30 working days of receipt of the emergency
34 department report, at which time the claim shall be deemed
35 complete. A claim from a professional provider shall be deemed
36 complete upon submission of a completed HCFA 1500 or its
37 electronic equivalent or other format adopted by the National
38 Uniform Billing Committee, and reasonable relevant information
39 requested by the plan within 30 working days of receipt of the
40 claim. The provider shall provide the plan reasonable relevant

1 information within 10 working days of receipt of a written
2 request that is clear and specific regarding the information
3 sought. If, as a result of reviewing the reasonable relevant
4 information, the plan requires further information, the plan shall
5 have an additional 15 working days after receipt of the
6 reasonable relevant information to request the further
7 information, notwithstanding any time limit to the contrary in
8 this section, at which time the claim shall be deemed complete.

9 (d) This section shall not apply to claims about which there is
10 evidence of fraud and misrepresentation, to eligibility
11 determinations, or in instances where the plan has not been
12 granted reasonable access to information under the provider's
13 control. A plan shall specify, in a written notice sent to the
14 provider within the respective 30 or ~~40~~ 45 working days of
15 receipt of the claim, which, if any, of these exceptions applies to
16 a claim.

17 (e) If a claim or portion thereof is contested on the basis that
18 the plan has not received information reasonably necessary to
19 determine payer liability for the claim or portion thereof, then the
20 plan shall have 30 working days or, if the health care service plan
21 is a health maintenance organization, 45 working days after
22 receipt of this additional information to complete reconsideration
23 of the claim. If a claim, or portion thereof, undergoing
24 reconsideration is not reimbursed by delivery to the claimant's
25 address of record within the respective 30 or 45 working days
26 after receipt of the additional information, the plan shall pay the
27 greater of fifteen dollars (\$15) per year or interest at the rate of
28 15 percent per annum beginning with the first calendar day after
29 the 30- or 45-working-day period. A health care service plan
30 shall automatically include the fifteen dollars (\$15) per year or
31 interest due in the payment made to the claimant, without
32 requiring a request therefor.

33 (f) (1) The obligation of the plan to comply with this section
34 shall not be deemed to be waived when the plan requires its
35 medical groups, independent practice associations, or other
36 contracting entities to pay claims for covered services. ~~For~~
37 ~~purposes of this section, those medical groups, independent~~
38 ~~practice association, and other contracting entities are designated~~
39 ~~as subcontractors.~~ This section shall not be construed to prevent
40 a plan from assigning, by a written contract, the responsibility to

1 pay interest and late charges pursuant to this section to medical
2 groups, independent practice associations, or other entities.

3 (2) If a physician has a contract with a plan but does not have
4 ~~a contract with a subcontractor, the physician may submit a claim~~
5 ~~to the plan, and the plan shall pay the claim pursuant to the terms~~
6 ~~of the contract between the plan and the physician. A physician~~
7 ~~submitting a claim to a health plan pursuant to this paragraph~~
8 ~~shall not bill the patient, except for copayments, deductibles, or~~
9 ~~other costs~~ *a contract with a medical group, independent*
10 *practice association, or other entity that has been required by the*
11 *plan to pay claims for covered services, the physician may submit*
12 *a claim to the plan for services covered by the plan and provided*
13 *to the enrollee of the plan, and the plan, and not the medical*
14 *group, independent practice association, or other entity, shall*
15 *pay the physician the claim pursuant to the terms of the contract*
16 *between the plan and the physician. A physician who has a*
17 *contract with a plan shall not bill the patient for services covered*
18 *by the plan, except for copayments, deductibles, and coinsurance*
19 *payments that are the responsibility of the patient.*

20 (g) A plan shall not delay payment on a claim from a
21 physician or other provider to await the submission of a claim
22 from a hospital or other provider without citing specific rationale
23 as to why the delay was necessary and providing a monthly
24 update regarding the status of the claim and the plan's actions to
25 resolve the claim, to the provider that submitted the claim.

26 (h) A health care service plan shall not request or require that
27 a provider waive its rights pursuant to this section.

28 (i) This section shall not apply to capitated payments.

29 (j) This section shall apply only to claims for services rendered
30 to a patient who was provided emergency services and care as
31 defined in Section 1317.1 in the United States on or after
32 September 1, 1999.

33 (k) This section shall not be construed to affect the rights or
34 obligations of any person pursuant to Section 1371.

35 (l) This section shall not be construed to affect a written
36 agreement, if any, of a provider to submit bills within a specified
37 time period.

38 SEC. 3. No reimbursement is required by this act pursuant to
39 Section 6 of Article XIII B of the California Constitution because
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or
2 infraction, eliminates a crime or infraction, or changes the
3 penalty for a crime or infraction, within the meaning of Section
4 17556 of the Government Code, or changes the definition of a
5 crime within the meaning of Section 6 of Article XIII B of the
6 California Constitution.

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